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Prior Authorizations for Medicare

Overview

In recent years, legislators and health insurers have leveraged prior authorization (PA) as a strategy to control healthcare costs and ensure patients receive appropriate treatments. When implemented effectively, these measures would ideally improve care and enhance transparency. That said, there have been concerns that poorly implemented PA measures may increase the administrative burden for providers while providing relatively little benefit to the patients. In fact, a 2018 audit showed that 75% of originally denied requests eventually ended up being approved. This suggests that the PA process ultimately proved to be an inefficient approach the majority of the time. Despite these inefficiencies, a new MGMA Stat poll conducted in May 2021 revealed that 81% of medical group practices report increased PA requirements, with only 2% reporting a decrease. There was a slight reprieve from PA requirements during the earlier portion of the COVID era, but since then it seems there has been a significant push to reinstate and expand these requirements.

Improving Seniors' Timely Access to Care Act (H.R. 3173)

On May 13th, 2021, House legislators reintroduced H.R. 3173 which attempts to improve care for seniors by streamlining and standardizing Medicare Advantage (MA) plans' use of PA. The bill aims to:

- Establish an electronic PA process
- Require the Dept. of Health and Human Services (HHS) to establish a process for "real-time decisions" for services that are common and usually approved
- Improve transparency by having MA plans report to the Centers for Medicare and Medicaid Services (CMS), including rate of approval/denials
- Encourage the use of PA programs that apply evidence-based medical guidelines

Ideally, the renewed efforts at effective implementation will achieve the desired transparency and oversight without inadvertently producing unnecessary burdens on providers and delaying care for patients. According to a 2020 American Medical Association (AMA) poll, 30% of physician respondents said PA led to a serious adverse event for a patient. As such, the AMA supports H.R. 3173 as a necessary measure to prioritize patient needs and reduce administrative burdens.

Additionally, MGMA helped to draft the original H.R. 3173 and continues to support its implementation. According to a recent statement, MGMA "has long advocated for health plans to reduce the magnitude of PA demands on medical practices," and, as such, they support the reintroduction of H.R. 3173 which would enact prior authorization rules for MA plans consistent with a 2018 industry consensus agreement. In 2020, the CMS published a proposed rule that streamlined PA processes, but it only applied to Medicaid and CHIP managed care plans, state Medicaid and CHIP fee-for-service programs, and Qualified Health Plans (QHP) issuers on the Federally Facilitated Exchanges (FFEs). MGMA continues to assert the importance of including MA plans in this rule through H.R. 3173.

APS continues to monitor the developments on this topic and will keep you abreast of new information as it arises. Please contact your Practice Manager for any additional questions.

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